**Category 1 DSRIP Project Summary**

**Seton Medical Center – Harker Heights – Project 013122392.1.100**

**Project Area, Option and Title:** 1.1 Expand Primary Care Capacity, 1.1.2 Expand Existing Primary Care Capacity

**RHP Project Identification Number:** 013122392.1.100

**Performing Provider Name:** Seton Medical Center – Harker Heights

**Performing Provider TPI #:** 013122392

**Project Summary:**

* **Provider Description:** Seton Medical Center – Harker Heights (SMCHH)will support the Greater Killeen Free Clinic. This clinic serves a ­­1,060 square mile area and a population of approximately 300,000.
* **Intervention:** This project will expand existing primary care capacity to provide patients with increased access to primary care services. SMCHH proposes to support Greater Killeen Free Clinic by adding additional primary care staff. This project will provide delivery of more preventive, primary and chronic care services in our community by expanding existing capacity. Onsite provider care will be provided by a 0.5 FTE Nurse Practitioner, 0.5 FTE Registered Nurse, and 0.5 FTE Social Worker.
* **Project Need:** With twice the amount of population per primary care provider than the national average; in a 2013 needs assessment Bell County participants listed access to care as the highest ranking health priority. Access to primary care services is often delayed or not even initiated for uninsured individuals and members of medical aid programs who do not have established relationships with primary care physicians in Bell County. Delays in care can lead to symptom exacerbation and the need for emergency care that may be preventable.
* **Target Population:** The intervention of these services will increase access to primary care services for a number of low-income individuals in Bell County including, Medicaid beneficiaries, uninsured individuals, underinsured individuals, and enrollees in the Bell County Indigent Care Program. Other eligible patient groups may include current participants of the Free Clinics and Medicaid beneficiaries who are members of the Bell County Patient Navigator Program. Of the 4,492 primary care encounters this project anticipates providing, we believe 95% will serve Medicaid/indigent individuals.
* **Expected Category 1 Project Benefit for Patients and a Description of the QPI Metric(s):** Seton Medical Center – Harker Heights will increase primary care clinic volume of visits and evidence of improved access for patients seeking services (I-12)

Increasing primary care capacity at the Greater Killeen Free Clinic will increase primary care services for the target population. This will include care for new patients and/or those that have already been diagnosed or show symptoms requiring evaluation for conditions such as hypertension, diabetes, COPD, or congestive heart failure. Seton Medical Center – Harker Heights expects approximately 95% of these individuals to be Medicaid beneficiaries and/or low income patients. The project will include approximately 4,492 Nurse Practitioner total additional Primary Care visits (encounters) and 2,080 additional Social Worker visits (encounters), by the conclusion of Year 5 (DY3: 832 Nurse Practitioner encounters and 416 Social Worker encounters, DY4: 1,664 Nurse Practitioner encounters and 832 Social Worker encounters, and DY5: 1,996 Nurse Practitioner encounters and 832 Social Worker encounters). In DY4, the quantifiable patient impact (QPI) will be measured by Milestone I-12, allowing us to establish the total number of visits (encounters) for the reporting period. Each year, we aim to increase the number of encounters at the greater Killeen Free Clinic, as measured by Milestone I-12, Metric I-12.1: Total number of visits (encounters) for reporting period.

* **Category 3 Measure(s):** IT – 1.11 Diabetes Care: BP control (<140/90mm Hg)

Reduced access to primary care physicians often prevents patients from seeking appropriate preventive care, especially for individuals with chronic conditions that require a more coordinated approach to managing and monitoring their ongoing needs. Expanding primary care capacity will result in patients being able to gain more access to care and also more timely access to care, avoiding long wait times for appointments. Chronic diabetes represents a significant challenge for the uninsured and Medicaid populations in Bell County, TX. This project will provide chronic disease management resource as a key indicator of the impact the project has on patients diagnosed with chronic diseases, SMCHH will collect and trend the blood pressure data of enrolled patients who have a diabetes diagnoses.

**Project Description:**

Seton Medical Center – Harker Heights proposes to expand primary care capacity in order to increase the delivery of care and access to care for the patients of Bell County. It will keep individuals and families healthy and therefore avoid more costly ER and inpatient care. This project will expand primary care capacity in Bell County to better accommodate the needs of the patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. This project will provide more preventive, primary and chronic care in our community by expanding existing capacity. We propose to recruit and hire additional nurse practitioners, registered nurses and social workers. According to the U.S Census and Applied Geographic Solutions data, within our service population of over 300,000, we have both a high percentage of older adults (9%) and more low-income residents with the per capita income and the median income lagging both the Texas and U.S. averages. As found in other geographic locations with high percentages of low-income or high percentages of the elderly, our patients have high rates of chronic, but potentially preventable diseases such as diabetes, hypertension, and heart disease. Expanding primary care capacity for the Killeen community will provide additional access and services to the uninsured, underinsured, and Medicaid populations. Seton Medical Center – Harker Heights project will improve access to primary care services and increase the volume of primary care visits that may otherwise have been treated episodically in an Emergency Department or other higher cost setting. Of the 4,492 primary care encounters this project anticipates providing, we believe 95% will serve Medicaid/indigent individuals.

*Goals and Relationship to Regional Goals*

Through our project, the primary care needs of patients will be better met, allowing them to receive the right care at the right time in the right setting. Achieving our project goals will improve access across the continuum of preventive, primary and chronic care and further increase efficiencies to maximize our current capacity.

**Project Goals:**

* Increase primary care capacity by hiring additional primary care providers
* Increase volume of primary care clinic visits for targeted population
* Reduce inappropriate utilization of the emergency department
* Reduce unnecessary health care expenses

This project supports the Region’s goals of providing patients with timely access to primary health care services in the most appropriate and cost-efficient settings, thereby improving patient outcomes and reducing acute care utilization.

**3 Year Expected Outcome:**

Seton Medical Center – Harker Height plans to add 0.5 FTE nurse practitioner, 0.5 FTE registered nurse and 0.5 FTE social worker to better meet the needs of our patient population. In turn, this will provide the opportunity to better serve our target population with at least an additional 832 Nurse Practitioner and 416 Social Worker visits in DY3.

**Starting Point/Baseline:**

While the Greater Killeen Clinic had 3,030 patient visits in 2012, we will exclude these from our baseline data due to the providers included in this project are unrelated and will be entirely new. Only the volumes of these additional providers will be captured in our outcomes data. With this project the Greater Killeen Free Clinic intends to expand its primary care capacity and services to include care for chronic conditions in 2014.

**Quantifiable Patient Impact:**

Seton Medical Center – Harker Heights will use HHSC’s recommended QPI (encounters) for this project. Each year we will seek to increase the number of patients that are receiving care in the Greater Killeen Free Clinic. Over the course of the project, we expect the total patient impact to be approximately 4,492 Nurse Practitioner total additional Primary Care visits (encounters) and 2,080 additional Social Worker visits (encounters), by the conclusion of Year 5 (DY3: 832 Nurse Practitioner encounters and 416 Social Worker encounters, DY4: 1,664 Nurse Practitioner encounters and 832 Social Worker encounters, and DY5: 1,996 Nurse Practitioner encounters and 832 Social Worker encounters). In DY4, the quantifiable patient impact (QPI) will be measured by Milestone I-12, allowing us to establish the total number of visits (encounters) for the reporting period. Each year, we aim to increase the number of encounters at the greater Killeen Free Clinic, as measured by Milestone I-12, Metric I-12.1: Total number of visits (encounters) for reporting period.

**Rationale:**

Bell County is a designated Medically Underserved Area due to a shortage of primary care providers, high infant mortality, high poverty, and/or high elderly population (U.S. Department of Health & Human Services, Health Resources and Services Administration). The median household income in Bell County is $49,466 with approximately 15% of residents at or below the poverty level (U.S. Department of Health & Human Services, Health Resources and Services Administration). Low-income and elderly populations often lack resources for seeking medical care, are more likely to suffer from chronic disease conditions, and have been found to be more likely to use the emergency department for non-emergent care. These populations are also the most likely to benefit from an expansion of primary care capacity. With twice the amount of population per primary care providers than the national average, in a 2013 needs assessment Bell County participants listed access to care as the highest ranking health priority. One of the key themes that was repeatedly cited by survey respondents were the challenges to low-income patients accessing primary care. Per the Texas Medical Association, the number of Texas physicians accepting new Medicaid patients has declined by 36% from 67% in 2000 to 31% in 2012 (Bell County Community Health Needs Assessment, June 2013). Given the impact lifestyle choices have on chronic disease, lifestyle metrics are used to identify opportunities and needs; in Bell County, all of the healthy lifestyle metrics score below the desired national benchmarks (see the below table for an example) (Ibid).

|  |  |  |
| --- | --- | --- |
|  | **National 90th Percentile** | **Bell County** |
| Adult Smoking | 14% | 23% |
| Adult obesity | 25% | 29% |
| Physical Inactivity | 21% | 28% |

By increasing the overall primary care capacity, there are beneficial results like better health outcomes, improved patient satisfaction, more appropriate utilization of resources and reduced cost of services. Adding providers to increase access to primary care will play a key role in improved disease management and will better address the chronic care needs of many of our patients rather than episodic care. With an increase of providers in place we can focus on more primary care delivery and data driven care, using technology to assist us with models of care for conditions such as diabetes, hypertension, and heart disease. The following milestones have been chosen for our project based on the core components:

* P-5. Milestone: Train/hire additional primary care providers and staff
* I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

Currently, our community has insufficient access to primary care services placing a significant strain on our health care delivery system. By increasing the number of primary care providers this project will enhance our existing delivery system and provide much needed increased primary care capacity.

**Community need identification number addressed:**

* CN.1.6 Limited access to primary care for preventive services with same day or next day appointments and extended hours.
* CN.3.5 Discontinuity of care and limited awareness of available resources and services among indigent, uninsured and Medicaid populations in Bell County leads to potentially avoidable ED and hospital utilization.

**Project Core Components:**

Seton Medical Center – Harker Heights project of expanding existing primary care capacity will meet the following required core project component:

*c) Expand primary care clinic staffing.* The recruitment and hiring of additional providers is the key component of this project. Within the overall intervention plan will be goals to ensure we are using the most appropriate strategies and resources in the recruitment/hiring of primary care providers.

Seton Medical Center – Harker Heights project of expanding existing primary care capacity will not meet the following core project components:

*a) Expand primary care clinic space.*

*b) Expand primary care clinic hours.*

The Bell County Free Clinic in Killeen currently has space available for an increase in clinic staffing; therefore this project does not require expanding clinic space. And because the need during current clinic hours already exceeds available staffing, this project also does not require expanded clinic hours at this time. Instead, the increase of primary care staffing during current clinic hours will help mitigate the current demand for primary care services.

**Customizable Process or Improvement Milestones:**

By adding a 0.5 FTE clinic social worker Seton Harker Heights will increase the volume of visits and improve access for patients seeking social services. As this service is a different scope than the traditional primary care encounter, we will use a customizable milestone (I-X.1) to capture these visits. In DY5, for example, Seton Harker Heights will provide 832 social services visits. The description of this milestone is: total number of additional social services encounters provided.

**Related Category 3 Outcome Measure(s):**

IT – 1.11 Diabetes Care: BP control (<140/90mm Hg)

Reduced access to primary care physicians often prevents patients from seeking appropriate preventive care, especially for individuals with chronic conditions that require a more coordinated approach to managing and monitoring their ongoing needs. Expanding primary care capacity will result in patients being able to gain more access to care and also more timely access to care, avoiding long wait times for appointments. Chronic diabetes represents a significant challenge for the uninsured and Medicaid populations in Bell County, TX. This project will provide chronic disease management resource as a key indicator of the impact the project has on patients diagnosed with chronic diseases, SMCHH will collect and trend the blood pressure data of enrolled patients who have a diabetes diagnoses.

**Relationship to Other Projects/Regional Goals:**

Many of the projects in this region are related to expansion of care and improving access to care. This project’s focus on expanding care will support and enhance these Category 1 projects in our RHP:

* 183086102.1.1 - Expand existing primary care capacity
* 020957901.1.1 - Expand existing primary care capacity
* 126936702.1.1 - Expand existing primary care capacity

A portion of this expanded primary care will be used to support the patient navigator program, which is another performing provider’s project in RHP8.

**Plan for Learning Collaborative:**

Seton Medical Center – Harker Heights will participate in an RHP 8 learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. Participation in these learning collaborative meeting events, as well individual training opportunities, regional spotlights and routine collaborative communications in the region, will allow Seton Medical Center – Harker Heights to work with other Providers within this specific project area or with similar targeted outcomes in an effort to share what we are doing, what we are learning, and how we might all leverage this shared information to continually improve and benefit the projects. The results of each learning collaborative meeting will be compiled and disseminated electronically to the entire RHP within 30 days after the meeting and will be archived on the RHP website hosted by the anchor ([www.tamhsc.edu/1115-waiver](http://www.tamhsc.edu/1115-waiver)).

In addition, opportunities may exist and will be explored for Seton Medical Center – Harker Heights to interact with providers in other RHPs who may have an expansion of primary care focus to expand learning and quality improvement initiatives. Additionally, Seton Medical Center – Harker Heights looks forward to participating in HHSC’s statewide learning collaborative activities as available.

**Project Valuation:**

SMCHH’s project valuation takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Expanding clinic staffing at the Killeen clinic will provide greater access to care to people who previously utilized ED services for non-emergent health care needs. The 175 non-emergency patients that visited the ED in 2012 and 2013 would have been better and faster served if they had easier access to additional primary care providers. By assisting this population in navigating the health care system and connecting them to a primary home rather than utilizing the ED results in significant cost savings to hospitals in the community. Patients will experience greater coordination of care, access to an integrated health system that includes primary care, specialty care, home health, case management and mental health services. In 2013, SMCHH experienced over 500 non-emergent visits in the ED, with each visit having an associated charge of $350. Redirecting those patients would provide a cost savings of over $175,000 in the ED. Considering that government payers comprise 60% of total ED utilization; this program would result in reduction of nearly $105,000 to State and Federal payers. Additional cost savings would unquestionably be realized as a result of increased primary care staffing, through early detection and prevention of chronic illnesses, and as a result, reduce the need for emergent care services or patients’ perceived need for emergent care services. Furthermore, the project seeks to accomplish delivery system reform by understanding that clinical primary care providers are in a shortage in this community and additional financial support is needed in order to maintain and expand the availability of primary care services. The systemic cost of providing health care to the community will be reduced in the aggregate by making this investment in local primary care access.